MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • General Medicine

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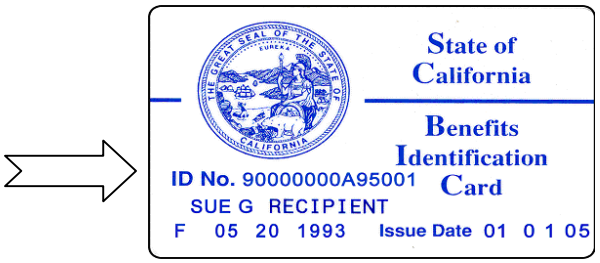
Contents

Implementation Delay: New Billing Requirements Prohibit Social Security Numbers

Implementation of the new billing requirements that prohibit most providers from billing Medi-Cal or the Child Health and Disability Prevention (CHDP) program using a recipient's Social Security Number (SSN) will be delayed until further notice. This delay will allow the California Department of Health Services (CDHS) to conduct further outreach to recipients and providers. A notice will be mailed to recipients reminding them of the importance of taking their Benefits Identification Card (BIC) with them when they need services from Medi-Cal providers.

All providers are encouraged to use the 14-character Medi-Cal identification number from the recipient's BIC or paper ID card when submitting claims. The ID number is located on the front of the card and consists of a 9-digit Client Index Number, a Check Digit and a 4-digit Issue Date.



Instructions for Entering BIC IDs on Claim Forms

Instructions for entering the required 14-character BIC ID number on claim forms are found on the following provider manual pages:

Form Name	Provider Manual Section, Page
Appeal Form (90-1)	appeal form, page 5
Claims Inquiry Form (CIF)	cif co, page 8
HCFA 1500	hcfa comp, page 3
Resubmission Turnaround Document (RTD) (Form 65-1)	resub comp, page 4

The issue date is used to deactivate cards that have been reported as lost or stolen.

Providers should instruct recipients who do not have a valid BIC or paper ID card, or who need to report a lost or stolen BIC, as follows:

- Supplemental Security Income and State Supplementary Payment Program (SSI/SSP) and Medi-Cal recipients should contact their county welfare office.
- County Medical Services Program (CMSP) recipients should contact their local CMSP worker.
- California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) recipients should contact their local county CCS office or the state GHPP office.

Please see **Implementation Delay**, *page 2*

Implementation Delay *(continued)*

Providers are required to make a good faith effort to obtain the recipient's BIC information. A good faith effort means that the provider attempts to obtain the BIC information from the recipient at the time the service is provided and makes a subsequent attempt to obtain the BIC or other appropriate documentation from the recipient.

Implementation Delay – Eligibility Verification Changes
Changes to prevent providers from using a recipient's SSN for eligibility verification will be delayed until after the new billing requirements have been implemented.

Use of Social Security Numbers
CDHS recognizes the importance of protecting the identity and the health information of recipients and strongly encourages all providers to avoid using a recipient's SSN whenever possible. This includes avoiding the use of the SSN for the purposes of eligibility verification, submission of *Treatment Authorization Requests* (TARs) and administrative billing.

Protecting Health and Identity Information/Mailing Paper Claims and Forms
Providers are reminded of the importance to protect the identity and health information of recipients.

Hardcopy Medi-Cal claim forms contain Protected Health Information (PHI). To protect the confidentiality and privacy of Medi-Cal recipients, it is important to submit these forms to the appropriate address. Below is a list of mailing addresses for each form. If you have any questions, please contact the Telephone Service Center (TSC) at 1-800-541-5555.

***Appeal Form* (90-1)**
Attn: Appeals Unit
EDS
P.O. Box 15300
Sacramento, CA 95851-1300

HCFA 1500
EDS
P.O. Box 15700
Sacramento, CA 95852-1700

***Claims Inquiry Form* (CIF)**
EDS
P.O. Box 15300
Sacramento, CA 95851-1300

***Resubmission Turnaround Document* (RTD) (65-1)**
EDS
P.O. Box 15200
Sacramento, CA 95851-1200

Please see future *Medi-Cal Updates* for more information.

Newborn Screening Test Rate Increase

The February *Medi-Cal Update* stated that the rate for HCPCS code S3620 (newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel [e.g., galactose; hemoglobin electrophoresis; hydroxyprogesterone, 17-d; phenylalanine (PKU); and thyroxine, total]) increased to $95.75, effective retroactively for dates of service from August 1, 2006 through December 31, 2006.

However, S3620 was not an active Medi-Cal reimbursement code until November 1, 2006. Therefore, retroactively for dates of service from August 1, 2006 to October 31, 2006, the rate for HCPCS local code Z2500 (newborn screening panel), which was replaced by S3620, was $95.75.

Effective retroactively for dates of service from November 1, 2006 to December 31, 2006, the rate for S3620 was $95.75. For dates of service on or after January 1, 2007, the rate is increased to $102.75.

Genetic Screening Manual Updates

Updates were made to remove the word "disease" from all references to "genetic disease screening" in various sections of the Part 1 and Part 2 manuals. Additionally, references to the MSMM (Maternal Serum Multiple Marker) were changed to XAFP (California Expanded AFP Screening Program), and the timeframe for XAFP screening after chorionic villus sampling was changed to 15 – 20 weeks in the *Genetic Screening* section of the Part 2 manual.

The updated information is reflected on manual replacement pages mcp cohs 3 (Part 1), gene 1, 2, 3 and 6 (Part 2), gene ex 1 thru 3 (Part 2), path hema ex 1 (Part 2), path molec 1 (Part 2) and preg early 4 (Part 2).

CPT-4 Codes 76376 and 76377 Terminated

Effective for dates of service on or after April 1, 2007, CPT-4 codes 76376 and 76377 are no longer Medi-Cal benefits. The California Department of Health Services' (CDHS) Benefits Branch has determined these two codes to be an integral part of the primary imaging procedure. Therefore, these codes are not separately reimbursable.

CPT-4 Code	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation
76377	requiring image post-processing on an independent workstation

This information is reflected on manual replacement page tar and non cd7 2 (Part 2).

CPT-4 Codes Rates Established

Effective for dates of service on or after April 1, 2007, rates for CPT-4 codes 90767 (additional sequential infusion, up to one hour), 90768 (concurrent infusion) and 90772 (therapeutic, prophylactic or diagnostic injection) have been established. Providers can view these established rates on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "Medi-Cal Rates" link on the home page. Podiatrist providers will no longer be reimbursed for code 90767.

Progestasert IUD No Longer a Medi-Cal Benefit

Effective for dates of service on or after April 1, 2007, HCPCS code X1514 (Progestasert®), a hormonal intrauterine device (IUD), is no longer a benefit as it was discontinued in 2001. Code X1532 (Mirena Intrauterine System®) is a Medi-Cal benefit and may be used instead.

This information is reflected on manual replacement pages fam planning 7 (Part 2) and non ph 11 (Part 2).

Rituximab (Rituxan) Documentation Criteria Correction

The December 2006 *Medi-Cal Update* erroneously stated *Treatment Authorization Request* (TAR) requirements for HCPCS code J9310 (rituximab, 100 mg). Rituximab does not require a TAR.

All other previously published policy remains unchanged.

This information is reflected on manual replacement page inject 46 (Part 2).

Annual Family PACT Updates and Policy Clarification – Correction

The Family PACT benefits grid that ran in the January 2007 *Medi-Cal Update* contained errors. The grid and the introductory text from the article are reproduced below with **the corrected information in bold**. The following information replaces page 9 of the Family PACT Provisional Services Benefits Grid (see June 2006 *Medi-Cal Update*, Part 2 bulletin).

Secondary Diagnosis: Cervical Abnormalities

A secondary diagnosis code is required for cervical abnormality diagnostic and treatment services. These services are restricted to females 15 to 55 years of age.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
ICD-9-CM 795.01 795.02 795.03 795.04 795.05 622.2	 ASC-US Pap ASC-H Pap LGSIL Pap HGSIL Pap Abn Pap with HPV high risk pos. Presumptive Dx. Leukoplakia, cervix	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies	None	Pelvic infection resulting from cervical treatment Hemorrhage from cervical biopsy or treatment site requiring surgical repair Vaso-vagal episode
795.00	AGC Pap	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 58110 Endometrial biopsy (19)	• 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies **58110ZM Supplies**	None	
622.11 622.12 233.1	CIN I (biopsy) CIN II (biopsy) CIN III (biopsy)	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 57511 Cryocautery of cervix (16) 57460 LEEP (16)	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology • 88307 Surgical pathology (17)	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 57511ZM Supplies 57460ZM Supplies	None	
795.09	Other abnormal Pap	58100 Endometrial biopsy (20)	• 88305 Surgical pathology	**58100ZM Supplies**		

(10) Complication services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR).*

(16) Restricted to biopsy proven CIN II or CIN III or persistent CIN I lesions of greater than 12 months.

(17) Restricted to biopsy specimens collected by LEEP procedure.

(18) DNA Amplified Probe HPV (High Risk Only) is covered in the following circumstances (see ASCCP, Guidelines 2002) and limited to one per year per client:

- Reflex HPV DNA testing after an ASC-US cytology result.
- Follow-up of LSIL cytology result in women less than 21 years of age. HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post-colposcopy; Women with Paps read as ASC-H, LSIL, or HPV DNA positive ASC-US in whom CIN is not identified at colposcopy can be followed up at 12 months with HPV DNA testing in lieu of cytology at 6 and 12 months.
- Follow-up of women with biopsy proven untreated CIN I; HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post treatment of CIN II, III: HPV DNA test at least six months after treatment in lieu of follow-up cytology.

DNA Amplified Probe HPV testing is not covered for a diagnosis of HGSIL Pap, ICD-9-CM 795.04 or Leukoplakia cervix, ICD-9-CM 622.2.

(19) Endometrial biopsy is covered only if AGC (atypical glandular cells) cytology result and any of:

- "Atypical endometrial cells" on AGC cytology result.
- Woman is having abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer.
- Woman is 36 through 55 years of age.

(20) Endometrial biopsy restricted to women aged 40 years or older with a finding of endometrial cells on Pap and a recent history of menstrual irregularity.

2007 Poverty Level Income Guidelines

The 2007 Federal Poverty Income Guidelines are effective for the Family PACT (Planning, Access, Care and Treatment) Program for dates of service on or after April 1, 2007. The guidelines are used to determine financial eligibility for the program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Monthly Income	Annual Income
1	$ 1,702	$ 20,420
2	$ 2,282	$ 27,380
3	$ 2,862	$ 34,340
4	$ 3,442	$ 41,300
5	$ 4,022	$ 48,260
6	$ 4,602	$ 55,220
7	$ 5,182	$ 62,180
8	$ 5,762	$ 69,140
9	$ 6,342	$ 76,100
10	$ 6,922	$ 83,060
For each additional person, add	$ 580	$ 6,960

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site (**www.familypact.org**).

Family PACT Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered under the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

San Bernardino

April 12, 2007
8:30 a.m. – 4:30 p.m.

Clarion Hotel & Convention Center
295 North E Street
San Bernardino, CA 92401
(909) 381-6181

Oakland

June 7, 2007
8:30 a.m. – 4:30 p.m.

Park Plaza Hotel
150 Hegenberger Road
Oakland, CA 94621
(510) 635-5000

Please see **Family PACT**, *page 6*

Family PACT *(continued)*

For a map and directions to these locations, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location.

Registration
To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

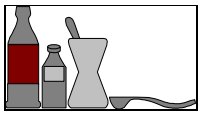
- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.



DRUG USE REVIEW
Educational Information

Lipotropics and Liver Function/Cholesterol Testing in the Medi-Cal Fee-For-Service Population

High cholesterol is a major contributor to coronary heart disease (CHD). There are approximately 100 million people with high cholesterol (>200mg/dL) in the United States.[1] Heart disease is the leading cause of death in the United States. High cholesterol attributes to narrowing of the arteries and plaque formation in coronary arteries.[2] High cholesterol is a changeable risk factor in heart disease. Some instances of high cholesterol can be familial, but diet also contributes to a patient's total cholesterol count.

There are different types of medications used to help lower cholesterol levels in the body. These include HMG-CoA Reductase Inhibitors (statins), other anti-lipemic agents (non-statins) and combination therapy. In addition to pharmacologic treatment for high cholesterol, there are also therapeutic lifestyle changes (TLC) that are essential to assist in the lowering of cholesterol.[3]

The Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III – ATP III) recommends that providers follow a progression of drug therapy and cholesterol evaluation schedule. They suggest the following:[4]

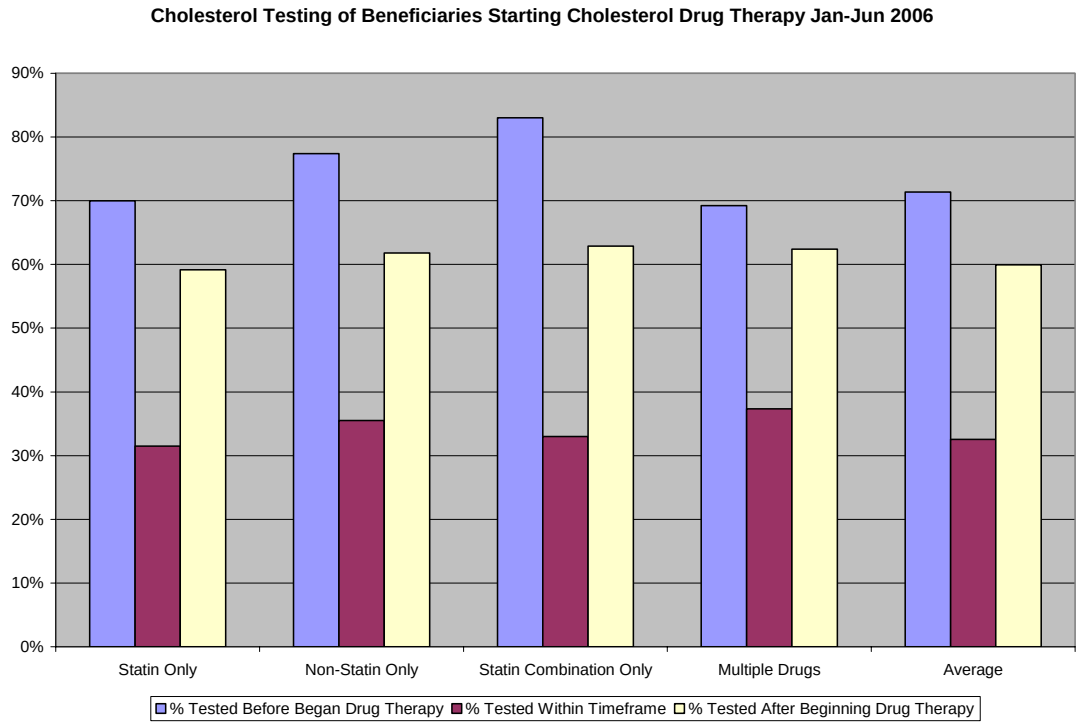
- Initiate LDL-lowering drug therapy and check cholesterol levels in six weeks.
- If the LDL goal is not realized, increase the dose of medication or add another type of cholesterol-lowering medication to the current regimen and recheck in six weeks.
- If the LDL goal is met, then continue the course of treatment including therapeutic changes and recheck every four to six months. If the goal is not met, then consider a referral to a specialist.

A retrospective study of Medi-Cal fee-for-service (FFS) recipients was conducted to determine if providers are following ATP III guidelines for cholesterol testing in patients starting cholesterol drug therapy. Since laboratory test results are not available to Medi-Cal to determine if lower cholesterol levels were achieved, the study focused on whether there was appropriate follow-up after patients began cholesterol drug treatments. Cholesterol testing included both cholesterol screening tests and liver function tests. Patients who were continuously eligible for 11 out of 12 months during the period of October 2005 through September 2006 and started cholesterol drug therapy between January through June 2006 were included in the study.

- 11,317 Medi-Cal recipients who met the continuous eligibility criteria had at least two claims for cholesterol medications during the study period, and had no claims for cholesterol medications in the last six months of 2005.
  - 60 percent had follow-up testing after starting drug therapy, though only 32.5 percent of the recipients had follow-up testing within the ATP III guidelines.
  - 71 percent of recipients were tested prior to beginning cholesterol drug therapy.

Please see **Drug Use Review**, *page 8*

Drug Use Review *(continued)*



The above results show that providers are providing follow-up care for their patients on cholesterol medications. Medi-Cal wants to make certain that recipients that utilize cholesterol medication are getting the best possible care.

- Providers should follow the current ATP III guidelines and other best practices with respect to initiating therapy and laboratory follow-up.
- Pharmacists can use prescription consultation as an opportunity to remind patients to have their cholesterol tested at the proper times after initiating or changing therapy. The pharmacist can encourage them to make appropriate lifestyle changes to help lower their cholesterol through non-pharmacologic means.
- Providers and pharmacists should consult their patients on the side effects of these medications, and the importance of using these medications correctly. Patients should also be monitored and informed about possible drug-drug interactions if they are taking more than one cholesterol-lowering medication.

References

1. American Heart Association. Heart Disease and Stroke Statistics – 2006 Update. Dallas, TX: American Heart Association; 2006. Available at **http://www.americanheart.org**.
2. National Committee for Quality Assurance (NCQA). Cholesterol Management After a Heart Attack. State of Health Care Quality Report, 2003.
3. Grundy, S, Cleeman, J, et al. Implications of Recent Clinical Trials for the National Cholesterol Education Program (NCEP) Adult Treatment Panel III Guidelines. Circulation. 2004; 110: 227-239.
4. National Cholesterol Education Program. Executive summary of the third report of the National Cholesterol Education Program (NCEP). Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III). Bethesda, MD: National Institutes of Health; 2002.

Please refer to pages 36-37 and 36-38 in the Medi-Cal Drug Use Review manual.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs.*

Changes, effective March 1, 2007

Drug	**Size and/or Strength**	
INSULIN		
(A separately payable benefit for recipients in nursing facilities, including subacute patients.)		
Injection		
Lente, NPH, Protamine Zinc, Semilente, Ultralente		
	40 Units/cc	10 cc
	80 Units/cc	10 cc
	100 Units/cc	10 cc
Lente, NPH, Protamine Zinc (purified pork)	100 Units/cc	10 cc
Regular	40 Units/cc	10 cc
	80 Units/cc	10 cc
	100 Units/cc	10 cc
Regular (purified pork)	100 Units/cc	10 cc
Globin	40 Units/cc	10 cc
	80 Units/cc	10 cc
	100 Units/cc	10 cc
~~**Others – specify name and strength**~~		
INSULIN (HUMAN)		
(A separately payable benefit for recipients in nursing facilities, including subacute patients.)		
Injection		
Regular	100 Units/cc	10 cc
Lente	100 Units/cc	10 cc
NPH	100 Units/cc	10 cc
NPH 50% and Regular 50%	100 Units/cc	10 cc
NPH 70% and Regular 30%	100 Units/cc	10 cc
Ultralente	100 Units/cc	10 cc
~~**Others – specify name and strength**~~		

Changes, effective May 1, 2007

Drug	**Size and/or Strength**
***** QUININE	
Capsules or tablets	200 mg
	325 mg
*** Restricted to claims submitted with dates of service prior to May 1, 2007.**	
***** QUININE SULFATE	
Tablets or capsules	
*** Restricted to claims submitted with dates of service prior to May 1, 2007.**	

Change in Coverage of Over-the-Counter Insulin (Human)

The Medi-Cal drug program has discovered an error in the listing of over-the-counter insulin and human insulin that has caused confusion for Pharmacy providers. The listing of "Others – specify name and strength" was inadvertently maintained in the manual. Insulin coverage without prior authorization is only for the specific package sizes listed. However, because of this confusion, Medi-Cal will provide continuing coverage for those recipients who have received a prescription for an unlisted package size (for example, a pen or cartridge) within the last 100 days, and will continue to allow payment without prior authorization as long as the recipient obtains a refill of their insulin within 100 days of their last refill.

Change in Coverage of Quinine Products

Medi-Cal is requiring prior authorization for Quinine-containing products, pursuant to the federal Food and Drug Administration (FDA) order to manufacturers to cease manufacturing unapproved products containing quinine, including quinine sulfate and any other salt of quinine on, or after February 13, 2007. The FDA has also ordered manufacturers to cease shipping such products interstate on or after June 13, 2007. After these dates, only FDA approved quinine products may be manufactured and shipped interstate. This action is described in the Federal Register of December 15, 2006, [71 FR 75557].

The FDA action does not affect quinine drug products marketed with FDA approval. The FDA has approved one quinine drug product as a prescription drug solely for the treatment of uncomplicated malaria caused by the parasite Plasmodium falciparum. It contains quinine sulfate as the active ingredient without any additional active ingredients in 324 mg. capsules and is sold under the trade name Qualaquin (quinine sulfate). This product is available through prior authorization.

Suspended Drugs Reinstated to Contract Drugs List

In June 2005, the suspended drugs and/or certain administrations of said drugs were correctly stricken in the *Drugs: Contract Drugs List Part 1 – Prescription Drugs* section of the Pharmacy manual. However, as these pages were updated each month, these specific drugs and/or administrations were inadvertently deleted from the manual section, but instead should have remained stricken.

The following drugs, or administrations, if specified, have been placed back into the appropriate manual section and will remain suspended until further notice.

CETIRIZINE HCL	LORATADINE
CICLOPIROX, 0.77% lotion	METHYLERGONOVINE MALEATE, ampule
CIPROFLOXACIN HCL	NEFAZODONE HCL
CITALOPRAM HBR	OLMESARTAN MEDOXOMIL, 5 mg tablets
DESLORATADINE	OMEPRAZOLE
ESTROGENS, A, SYNTHETIC CONJUGATED	OMEPRAZOLE MAGNESIUM
FENTANYL CITRATE	PANTOPRAZOLE SODIUM
FEXOFENADINE HCL	QUINAPRIL HCL
GATIFLOXACIN	RABEPRAZOLE SODIUM
KETOTIFEN FUMARATE	ROFECOXIB
LEVONORGESTREL, ETHINYL ESTRADIOL, AND PREGNANCY TEST	TOLTERODINE TARTRATE, tablets
LINEZOLID	UNOPROSTONE ISOPROPYL

Instructions for Manual Replacement Pages — Part 2

March 2007

General Medicine Bulletin 392

Remove and replace: *Contents for General Medicine* iii/iv *

Remove and replace:
chemo 13/14 *
fam planning 7/8
gene 1 thru 6
gene ex 1 thru 3
inject 3/4 and 45/46
non ph 11/12
path hema ex 1/2
path molec 1
preg early 3/4
surg 5/6 *
tar and non cd5 7/8 *
tar and non cd7 1/2

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section: 36-37
Insert: 36-37/38

* Pages updated due to ongoing provider manual revisions.